SD Medicaid PCP Health Home Outcome Recommendations

Goal 1: Improve the health of Medicaid Health Home recipients with chronic conditions.	Measures	Data Source	Measure Specification	How HIT will be Utilized	Core Service
Clinical Outcomes	**Depression:** Percentage of PCP-HH recipients aged 12 years through 17 years screened for clinical depression using an age appropriate standardized tool and follow-up documented.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients aged 12 years through 17 years screened for depression in the previous 12 months **Denominator** = number of all PCP-HH recipients aged 12 years through 17 years in the previous 12 months x 100	Results will be reported in a spreadsheet by individual primary care health home.	Health Promotion
	Depression: Percentage of PCP-HH recipients aged 18 years and older screened for clinical depression using an age appropriate standardized tool and follow-up documented.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients aged 18 years and older screened for depression in the previous 12 months **Denominator** = number of all PCP-HH recipients aged 18 years and older in the previous 12 months x 100	Utilizing the HH's electronic health record, results will be reported in a spreadsheet by individual primary care health home.	Health Promotion & Comprehensive Care Management
	Substance Abuse: Percentage of PCP-HH recipients age 12 years and older who were screened for tobacco, alcohol and other drug dependencies within the reporting period.	Recipient Electronic Health Record	**Numerator =** Number of PCP-HH recipients age 12 years and older screened for tobacco, alcohol and other drug dependencies in the previous 12 months **Denominator =** Number of all PCP-HH recipients	Utilizing the HH's electronic health record, results will be reported in a spreadsheet by individual primary care health home.	Health Promotion & Comprehensive Care Management

			aged 12 years and older in the previous 12 months x 100		
	Substance Abuse: Percentage of PCP-HH recipients age 13 years and older (adolescents and adults) with a new episode of alcohol or other drug (AOD) dependence who received the following: ▪ Initiation of AOD treatment	Recipient Electronic Health Record	**Initiation of AOD Treatment Numerator** = Number of PCP-HH recipients aged 13 years and older with initiation of AOD treatment through an inpatient admission, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. **Denominator** = Recipients 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18 years and older) and a total rate. The total rate is the sum of the two denominators.	Utilizing the HH's electronic health record, results will be reported in a spreadsheet by individual primary care health home.	Health Promotion & Comprehensive Care Management
	Substance Abuse: Percentage of PCP-HH recipients age 13 years and older (adolescents and adults) with a new episode of alcohol or other drug (AOD) dependence who received the following: ▪ Engagement of AOD treatment	Recipient Electronic Health Record	**Engagement of AOD Treatment Numerator =** Initiation of AOD treatment and two or more inpatient admission, outpatient visits, intensive outpatient encounters, or partial hospitalizations	Utilizing the HH's electronic health record, results will be reported in a spreadsheet by individual primary care health home.	Health Promotion & Comprehensive Care Management

			with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. **Denominator** = Recipients 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18 years and older) and a total rate. The total rate is the sum of the two denominators.		
	Asthma: Percentage of PCP - HH recipients aged 5 through 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication and remained on their medication during the measurement year. Two rates are reported. 1. % of PCP - HH recipients who remained on an asthma controller medication at least 50% of the treatment period.	Recipient Electronic Health Record	**Numerator** = For a given 90 day period number of PCP-HH recipients between the ages of 5 through 50 years of age identified as having asthma and a prescription for a controller medication. **Denominator** = for a given 90 day period number of PCP-HH recipients between the age of 5 through 50 year	Results will be reported in a spreadsheet by individual primary care health home.	Comprehensive Care Management

	2. % of PCP-HH recipients who remained on an asthma controller medication @ least 75% of the treatment period.		of age identified as having asthma. **Numerator** = number of PCP-HH recipients on medication for asthma in the past 90 days with a medication possession ratio greater than 75%. **Denominator** = number of all PCP-HH recipients on medication for asthma in the past 90 days.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	
	Diabetes: Percentage of PCP - HH recipients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%.	Recipient Electronic Health Record	**Numerator** = For a given 90 day period, number of PCP-HH recipients between the age of 18 to 75 years old identified as having diabetes and a documented Hba1c in the previous 12 months for whom the most recent Hba1c level is less than 8% **Denominator** = For a given 90 day period, number of PCP-HH recipients between the age of 18 – 75 years of age identified as having diabetes and having a documented Hba1c in	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management

			the previous 12 months.		
	Diabetes: Percentage of PCP - HH recipients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients 18 – 75 years of age with diabetes whose most recent blood pressure in the previous 12 months was less than 140/90 mmHg. **Denominator** = total number of PCP-HH recipients in the previous 12 months 18-75 years of age with diabetes.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management
	Vascular Disease: Percentage of PCP - HH recipients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who's most recent LDL-C level was in control (less than 100 mg/dL).	Recipient Electronic Health Record	**Numerator** = During the reporting period, number of PCP-HH recipients age 18 years and older diagnosed with Ischemic Vascular Disease (IVD) who received at least one lipid panel profile within the last 12 months and whose recent LDL-C level was in control (less than 100mg/dl). **Denominator** = PCP-HH recipients age 18 years and older diagnosed with Ischemic Vascular Disease (IVD) who received at least one lipid panel profile within the last 12 months.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management

	Obesity: Percentage of PCP - HH recipients age 18- 74 years who had an outpatient visit and whom had their BMI documented during the reporting period or the year prior to the reporting period.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients age 18 - 74 with a documented BMI during the reporting period or the year prior to the reporting period **Denominator** = PCP-HH recipients 18-74 years of age who had an outpatient visit.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management
	Obesity: Percentage of PCP - HH children age 6 to 17 with a calculated BMP (Body Mass Percentile) at their most recent preventative service visit during the reporting period.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients age 6 to 17 years during the reporting period or during the current visit documented in the medical record in the denominator with a calculated BMP. **Denominator** = all active PCP-HH recipients.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management
	Cancer Screening: Percentage of PCP - HH women ages 50–75 who had a mammogram to screen for breast cancer.	Recipient Electronic Health Record	**Numerator** = During the reporting period, Number of PCP-HH women ages 50-75 who	The medication adherence, HEDIS indicators and meaningful use	Comprehensive Care Management

			had a mammogram to screen for breast cancer **Denominator**: Number of PCP-HH women ages 50-75	measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	
	Cancer Screening: Percentage of PCP - HH recipients ages 50–75 who had appropriate screening for colorectal cancer. Appropriate exams include colonoscopy, sigmoidoscopy or fecal occult blood tests.	Recipient Electronic Health Record	**Numerator** = During the reporting period, Number of PCP - HH recipients ages 50–75 who had appropriate screening for colorectal cancer. **Denominator** = Number of PCP - HH members ages 50–75	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Health Promotion
	Chronic Pain: Percentage of PCP - HH recipients aged 18 years and older with documentation of a pain assessment through discussion with the PCP - HH recipient including the use of a standardized tool(s) on each	Recipient Electronic Health Record	**Numerator** = Number of PCP - HH recipients aged 18 years and older with documentation of a pain assessment through discussion with the PCP - HH recipient including the use of a standardized	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will	Comprehensive Care Management

	visit AND documentation of a follow-up plan when pain is present.		tool(s) on each visit AND documentation of a follow-up plan when pain is present. **Denominator** = Number of PCP - HH recipients aged 18 years and older	utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	
	Hypertension: Percentage of PCP - HH recipients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mmHg) during the measurement year.	Recipient Electronic Health Record	**Numerator** = for a given 90 day period the number of PCP-HH recipients between the age of 18 through 85 years old in the denominator whose most recent blood pressure is adequately controlled during the measurement year. For the recipient's BP to be controlled, both systolic and diastolic BP must be less than 140/90mmHg140/90 mmHg. **Denominator** = for a given 90 day period total number of PCP-HH recipients between the age of 18 through 85 years old identified as having hypertension and who had at least one outpatient encounter with a diagnosis of HTN during the first six months of the	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management

			measurement year.		
Experience of Care	**Measure and Improve Performance:** The practice or practice designee surveys PCP - HH recipients to assess PCP - HH recipient/family experience on at least three of the following: Quality of Care, clinical outcomes, experience of care, access, communication, coordination, whole person care/self-management support.	PCP Health Home satisfaction survey	**Numerator** = Number of questions with a response of "usually" or "always" (the top two scores) for satisfaction related to quality of care, clinical outcomes and experience of care. **Denominator** = the total number of questions responded to within the survey.	Results of PCP-HH surveys will be reviewed and reported across the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management
Quality of Care	**Multiple Medication**s: Percentage of specified visits for PCP - HH recipients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements.	Recipient Electronic Health Record	**Numerator** = PCP-HH recipients age 18 years and older that have had a recipient visit within the reporting period and have a list of current medication in the PCP-HH electronic health record. **Denominator** = all active PCP-HH recipients that have had a visit in the reporting period.	PCP-HH attests to the presence of medication listing within the electronic health record as a matter of best practice as the data cannot be queried electronically. Future IT utilization will mirror meaningful use criteria and the Health Home will report electronically.	Comprehensive Care Management
	Pro-Active Patient Management: The practice uses PCP - HH recipient information, clinical data and evidence based guidelines to generate lists of PCP - HH recipients and proactively remind PCP - HH recipients and families and clinicians of services needed. The practice demonstrates that during the	Recipient Electronic Health Record/Practice Records	PCP-HH electronic health record or electronic care management system identifies PCP-HH recipient visits scheduled, and reminds PCP-HH recipients of said visits.	PCP-HH attests to the evidence of reminder systems. Future IT utilization will mirror meaningful use criteria and the Health Home will report electronically and identify the number of recipients requiring follow-up.	Health Promotion & Chronic Care Management

	past year it has proactively identified and provided outreach to PCP - HH recipients in need of services.				
Goal 2: Provide cost effective, high-quality health care services for Medicaid Health Home recipients.	**Measures**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**	**Core Service**
Experience of Care	**Chronic Pain**: Percentage of PCP - HH recipients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis. **Denominator** = Number of PCP-HH recipients with a primary diagnosis of low back pain.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines.	Comprehensive Care Management
Quality of Care	**Resource Utilization**: DSS tracks the accumulated Medicaid expenditures/ total resources expended to provide care for all Health Home PCP - HH recipients by tier.	Electronic Claims Data	**Numerator** = the accumulated Medicaid expenditures (inpatient, outpatient, pharmacy, ancillary services) associated with PCP-HH recipients by risk tier **Denominator** = total number of PCP-HH recipients by tier.	DSS will utilize its electronic claims system to identify total costs by tier and for the total	Comprehensive Care Management
	Resource Utilization: DSS	Electronic Claims	**Numerator** = the	DSS will utilize its	Comprehensive

75 and younger.	tracks the accumulated Medicaid expenditures/resources expended to provide care to all enrolled PCP-HH recipients.	Data	accumulated Medicaid expenditures (inpatient, outpatient, pharmacy, ancillary services) associated with all enrolled PCP-HH recipients **Denominator** = total number of enrolled PCP-HH recipients.	electronic claims system to identify total costs associated with PCP-HH recipients.	Care Management
	Accessing appropriate levels of care: The PCP-HH provides education on appropriate ER utilization and DSS tracks overall ER utilization to measure reductions over a 12-month period.	Electronic Claims Data	**Numerator** = Number of annual PCP-HH emergency room visits **Denominator** = total PCP-HH member months x 12 x 1,000.	DSS will utilize its electronic claims system to measure emergency room visits/1000 members/year.	Comprehensive Care Management
	Utilization Management Performance: The practice manages the PCP - HH recipient population for those 75 years of age and under . to reduce the overall hospitalizations over a 12 month period. DSS measures admits per thousand annually.	Electronic Claims Data	**Numerator** = For a 12 month period, utilizing the HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services and inpatient mental health services discharges calculate the total number of hospital bed days for al HH recipients under age 75 **Denominator** = the average number of PCP-HH recipients under age 75 during that same time period x 1,000.	DSS will utilize its electronic claims system to measure hospital bed days and its enrollment system to measure the average number of PCP-HH recipients to calculate admits per thousand.	Comprehensive Care Management
	Utilization Management Performance: The practice manages the PCP - HH recipient	Electronic Claims Data	**Numerator** = the number of PCP-HH recipients admitted to a hospital	DSS will utilize its electronic claims system to identify	Comprehensive Care Management

	population to reduce hospital readmissions for the same or similar diagnosis within a 30 day period over a 12 month period.		for the same or similar diagnosis within 30days of a hospital discharge **Denominator** = the total number of hospital discharges during the same reporting period.	hospital readmissions for the same or similar diagnosis within 30 days of a hospital discharge to measure readmission rates over a 12 month period.	
	Utilization Management Performance: The practice manages the PCP - HH recipient population 18 years of age and older to reduce hospital readmissions for the same or similar diagnosis within a 30 day period over a 12 month period.	Electronic Claims Data	**Numerator** = the number of PCP-HH recipients 18 years of age or older admitted to a hospital for the same or similar diagnosis within 30days of a hospital discharge **Denominator** = the total number of hospital discharges of PCP-HH recipients 18 years of age or older during the same reporting period.	DSS will utilize its electronic claims system to identify hospital readmissions for the same or similar diagnosis within 30 days of a hospital discharge to measure readmission rates over a 12 month period.	Comprehensive Care Management
	Track & Coordinate Care: The practice tracks referrals using a reporting log or electronic reporting system. The tracked referrals are those determined by the clinician to be important for a PCP - HH recipient's treatment or as indicated by practice guidelines.	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients referred by a clinician **Denominator** = all active PCP-HH recipients during the same reporting period.	The PCP-HH tracks identified referral through its electronic health record or practice management system.	Care Coordination
	Care Transition: Transition Record Transmitted to PCP-HH The practice tracks the percentage of patients, regardless of age, discharged from an inpatient facility to home or any of other site of care for whom a transition record was transmitted to the	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients with a transition record from an inpatient facility (hospital inpatient or observation, skilled nursing facility or rehabilitation facility) transmitted to the PCP-HH for follow-up care	The PCP-HH tracks follow-up care delivered within 24 hours of discharge through its electronic health record or practice management system.	Comprehensive Care Management

	facility or designated health professional for follow-up care within 24 hours of discharge.		within 24 hours of discharge. **Denominator =** All PCP-HH recipients discharges from an inpatient facility (hospital inpatient or observation, skilled nursing facility or rehabilitation facility) to home/self-care or any other site of care.		
	Follow-up After Hospitalization for Mental Illness: PCP HH tracks the percentage of HH recipients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Recipient Electronic Health Record	**Numerator** = An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to table FUH-C in the original measure documentation codes to identify visits) with a mental health practitioner within 7 days after discharge.. Include outpatient visits, an intensive outpatient encounters, or partial hospitalizations that occur on the day of discharge. **Denominator =** Recipients 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December	The PCP-HH tracks follow-up care delivered within 24 hours of discharge through its electronic health record or practice management system.	Comprehensive Care Management

			31 of the measurement year.		
Goal 3: Transform the primary care health care delivery system.	**Measures**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**	
Clinical Outcomes	N/A				
Experience of Care	**Self-Management**: Recipient & Family Support: Provide educational resources or refers at least 50% of PCP-HH recipients/families to educational resources to assist in self-management. .	Recipient Electronic Health Record	**Numerator** = the number of PCP-HH recipients that were provided educational resources or referrals **Denominator** = all active PCP-HH recipients during the same time period. Educational materials or referrals provided are to be documented in PCP-HH recipients electronic health record	PCP-HH Management report and attestation. Future goal is to receive the report electronically via the PCP-HH electronic health record.	Patient & Family Support
	Self-Management: Counsel at least 50% of PCP-HH recipients/families to adopt healthy behaviors associated with disease risk factors (tobacco use, nutrition, exercise & activity level, alcohol use).	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients that have been educated on health risks associated with disease risk factors. **Denominator** = Total number of active PCP-HH	PCP-HH Management report and attestation. Future goal is to receive the report electronically via the PCP-HH electronic health record.	Patient & Family Support

			recipients during the reporting period.		
	Plan & Manage Care: Conduct pre-visit preparations and collaborate with PCP-HH patient/family to develop an individual care plan that includes treatment goals. .	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients whose medication, laboratory, and radiology orders created by provider are recorded using CPOE/EHR. **Denominator** = Total number of active PCP-HH recipients during the reporting period.	PCP-HH Management report and attestation. Future goal is to receive the report electronically via the PCP-HH electronic health record.	Health Promotion & Chronic Care Management
	Plan & Manage Care: Provide the PCP-HH recipient/family a clinical summary of each relevant visit	Recipient Electronic Health Record	**Numerator** = Number of PCP-HH recipients that had a visit during the reporting period **Denominator** = all active PCP-HH recipients during the same time period.	PCP-HH Management report and attestation. Future goal is to receive the report electronically via the PCP-HH electronic health record.	Health Promotion & Chronic Care Management
Quality of Care	**Comprehensive Care**: The practice follows up with PCP - HH recipients who have not kept important appointments, such as for rechecks, preventive care, or post hospitalization.	Recipient Electronic Health Record/Practice Records	**Numerator** = Number of missed PCP-HH recipients appointments **Denominator** = Number of scheduled PCP-HH recipient visits in the reporting period.	PCP-HH Management report and attestation or an electronic report via the PCP-HH electronic health record.	Comprehensive Transitional Care & Follow-up
	Plan and Manage Care: Identify PCP-HH recipients/families who might benefit from additional care management support.	Recipient Electronic Health Record /Practice Records	**Numerator** = Number of recipients identified and referred for additional support services **Denominator** = all active PCP-HH recipients during the same time period.	PCP-HH Management report and attestation or an electronic report via the PCP-HH electronic health record.	Comprehensive Transitional Care & Follow-up

	Self-Management: Document self-management abilities for at least 50% of PCP-HH patients/families.	Recipient Electronic Health Record /Practice Records	**Numerator** = Number of PCP-HH recipients with self-management abilities documented in recipient health record **Denominator** = all active PCP-HH recipients during the same time period.	PCP-HH Management report and attestation or an electronic report via the PCP-HH electronic health record.	Patient & Family Support
	Self-Management: Provide self-management tools to enable PCP - HH recipients to record self care results for at least 50% of PCP-HH patients/families.	Recipient Electronic Health Record /Practice Tools	**Numerator** = Number of PCP-HH recipients utilizing self-management tools to record self care results **Denominator** = all active PCP-HH recipients during the same time period.	PCP-HH Management report and attestation or an electronic report via the PCP-HH electronic health record.	Patient & Family Support
	Track & Coordinate Care: Demonstrate the capability for electronic exchange key clinical information	PCP-HH Attestation	PCP-HH attests that their PCP-HH electronic Health Record has been functional for a twelve month period	PCP-HH Management report and attestation	Care Coordination
	Track & Coordinate Care: Provide an electronic summary of care record for more than 50% of referrals to the referred specialists.	Recipient Electronic Health Record	**Numerator** = Number of times PCP-HH recipient information was transferred (recipients electronic health record indicates a specialty referral) in a 90 day period **Denominator** = number of PCP-HH recipients actively enrolled in the PCP-H at any point during the 90 days x 90.	Electronic report via the PCP-HH electronic health record. .	Health Promotion & Chronic Care Management